CARITAS – 2233 N Hamline Ave Ste 207 St Paul MN 55113 o: 651-644-8235 f: 855-319-8073

Welcome! As a means of facilitating our bookkeeping system, we ask that you complete the following information. PLEASE PRINT ALL DATA

Client name: _____ Date of birth: _____
last first middle

Address: _____
street city state zip code

Where would you like statements to be sent? _____

Gender: M F Home phone: _____-_____-_____ Work phone: _____-_____-_____

Cell phone: _____-_____-_____ Which number do you prefer to be reached at? _____

Name of parent(s) or spouse: _____ Date of birth: _____

_____ Date of birth: _____

Names of siblings (for minors) _____ Date of birth: _____

or children _____ Date of birth: _____

_____ Date of birth: _____

Name of insured: _____ Social security #: ____-___-_____

Relationship to patient: _____ Name of employer: _____

Insurance company: _____ Policy/ID #: _____

Group #: _____ Phone #: _____-_____-_____ Address: _____

I understand that I am responsible for all fees not covered by insurance and that I will be charged for missed appointments and appointments not cancelled within 24 hours of the scheduled time.

Signature: _____ Date: _____

I would like this office to bill my insurance company, and this office may receive insurance payments for services provided. I also authorize the release of pertinent information regarding services provided for processing to Cathie G Welch, LLC.

Signature: _____ Date: _____

Office use only:

Dx: _____ Date of intake _____ Referred by: _____ Deductible: _____